Comparison of Statewide Plans 2007

Effective July 1, 2007 or October 1, 2007

The Local Choice 2007 Comparison of Statewide Plans

	Key Advantage Expanded			Key Advantage 200		
Plan year deductible (Key Advantage: applies to certain medical services as indicated on chart) (HDHP: applies to medical, behavioral health, and prescription drug services)	One Person $100	Two People $200	Family $300	**In-Network:** One Person $200 **Out-of-Network:** $400	Two People $400 $800	Family $600 $1,200
Out-of-pocket expense limit	One Person $1,000	Two People $2,000	Family $3,000	**In-Network:** One Person $1,500 **Out-of-Network:** $3,000	Two People $3,000 $6,000	Family $4,500 $9,000
Out-of-network benefits	Yes. Plan's payment reduced by 25% for covered medical and behavioral health services.			Yes. Once you meet the out-of-network deductible, you pay 20% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services.		
BlueCard® PPO and BlueCard Worldwide®	Included			Included		
Lifetime maximum	None			None		
Covered Services	In-Network You Pay			In-Network You Pay		
Ambulance travel	20% coinsurance after deductible			20% coinsurance after deductible		
Behavioral health and EAP *Inpatient treatment* • Facility services • Professional provider services *Outpatient professional provider visits*	 $200 copayment per stay $0 $15 copayment			 $300 copayment per stay $0 $20 copayment		
Employee Assistance Program (EAP) (up to 4 visits per incident)	$0			$0		
Dental *Dental plan year deductible* *Plan year maximum (except Orthodontics)* *Diagnostic and preventive services* *Primary services* *Complex restorative* *Orthodontic services*	One Person $25 $1,500 $0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance after dental deductible, with $1,500 lifetime maximum	Two People $50	Family $75	One Person $25 $1,200 $0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance after dental deductible, with $1,200 lifetime maximum	Two People $50	Family $75
Diagnostic tests, and x-rays (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	10% coinsurance, no deductible			10% coinsurance after deductible		
Doctor visits – on an outpatient basis *Primary care physicians* *Specialty care providers*	 $15 copayment $25 copayment			 $20 copayment $35 copayment		
Emergency room visits *Facility services* *Professional provider services -* • Primary care physicians • Specialty care providers *Diagnostic tests, and x-rays*	 $75 copayment per visit (waived if admitted) $15 copayment $25 copayment 10% coinsurance, no deductible			 $100 copayment per visit (waived if admitted) $20 copayment $35 copayment 10% coinsurance after deductible		
Home health services (90 visit plan year limit)	$0			$0		
Home private duty nurse's services	20% coinsurance after deductible			20% coinsurance after deductible		

Key Advantage 300	Key Advantage 500	High Deductible Health Plan
In-Network: One Person $300 / Two People $600 / Family $900 **Out-of-Network:** $600 / $1,200 / $1,800	**In-Network:** One Person $500 / Two People $1,000 / Family $1,500 **Out-of-Network:** $1,000 / $2,000 / $3,000	One Person $1,200 / Two People See Family / Family $2,400
In-Network: One Person $2,500 / Two People $5,000 / Family $7,500 **Out-of-Network:** $5,000 / $10,000 / $15,000	**In-Network:** One Person $3,000 / Two People $6,000 / Family $9,000 **Out-of-Network:** $6,000 / $12,000 / $18,000	One Person $5,000 / Two People See Family / Family $10,000
Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services.	Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services.	No coverage, except in emergency.
Included	Included	Included
None	None	None
In-Network You Pay	**In-Network You Pay**	**In-Network You Pay**
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
20% coinsurance per stay after deductible $0	20% coinsurance per stay after deductible $0	20% coinsurance after deductible 20% coinsurance after deductible
$25 copayment	$25 copayment	20% coinsurance after deductible
$0	$0	$0
One Person $25 / Two People $50 / Family $75 $1,200 $0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance after dental deductible, with $1,200 lifetime maximum	One Person $25 / Two People $50 / Family $75 $1,200 $0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance after dental deductible, with $1,200 lifetime maximum	One Person $25 / Two People $50 / Family $75 $1,500 $0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance after dental deductible, with $1,500 lifetime maximum
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$25 copayment $40 copayment	$25 copayment $40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$25 copayment $40 copayment 20% coinsurance after deductible	$25 copayment $40 copayment 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
$0	$0	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 200 In-Network You Pay
Hospice care services	$0	$0
Hospital services		
Inpatient treatment:		
• Facility services	$200 copayment per stay	$300 copayment per stay
• Professional provider services -		
• Primary care physicians	$0	$0
• Specialty care providers	$0	$0
Outpatient treatment		
• Facility services	$75 copayment	$100 copayment
• Professional provider services -		
• Primary care physicians	$15 copayment	$20 copayment
• Specialty care providers	$25 copayment	$35 copayment
• Diagnostic tests, and x-rays	10% coinsurance, no deductible	10% coinsurance after deductible
Infusion services		
Facility services	$0	$0
Professional provider services	$0	$0
Home services	$0	$0
Infusion medications -		
• Outpatient settings	$0	$0
• Home settings	$0	$0
Maternity		
Professional provider services (prenatal & postnatal care)		
• Primary care physicians	$15 copayment	$20 copayment
• Specialty care providers	$25 copayment	$35 copayment
	If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for physician care. If your doctor bills for these services separately, your payment responsibility will be determined by the services received.	
Delivery -		
• Primary care physicians	$0	$0
• Specialty care providers	$0	$0
Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)	$200 copayment per stay	$300 copayment per stay
Outpatient diagnostic tests	10% coinsurance, no deductible	10% coinsurance after deductible
Medical equipment, appliances, formulas and supplies	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient prescription drugs - mandatory generic		
*Retail up to 34-day supply**	Tier 1 – $10 copayment	Tier 1 – $10 copayment
*You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible	Tier 2 – $20 copayment Tier 3 – $35 copayment	Tier 2 – $20 copayment Tier 3 – $35 copayment
Mail Service up to 90-day supply	Tier 1 – $20 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment	Tier 1 – $20 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment
Routine vision (once every 24 months)		
Routine eye exam	$25 copayment	Not covered
Eyeglass frames (one pair)	Remaining cost after Plan pays $75	Not covered
Eyeglass lenses (one pair)		
• Single vision lenses	Remaining cost after Plan pays $50	Not covered
• Bifocal lenses	Remaining cost after Plan pays $75	Not covered
• Trifocal lenses	Remaining cost after Plan pays $100	Not covered
OR		
Contact lenses (any type)	Remaining cost after Plan pays $100	Not covered

Key Advantage 300 In-Network You Pay	Key Advantage 500 In-Network You Pay	High Deductible Health Plan In-Network You Pay
$0	$0	20% coinsurance after deductible
20% coinsurance per stay after deductible	20% coinsurance per stay after deductible	20% coinsurance after deductible
$0 $0	$0 $0	20% coinsurance after deductible 20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$25 copayment $40 copayment 20% coinsurance after deductible	$25 copayment $40 copayment 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
$0 $0 $0	$0 $0 $0	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
$0 $0	$0 $0	20% coinsurance after deductible 20% coinsurance after deductible
$25 copayment $40 copayment If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for physician care. If your doctor bills for these services separately, your payment responsibility will be determined by the services received.	$25 copayment $40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
$0 $0	$0 $0	20% coinsurance after deductible 20% coinsurance after deductible
20% coinsurance per stay after deductible	20% coinsurance per stay after deductible	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Tier 1 – $10 copayment Tier 2 – $20 copayment Tier 3 – $35 copayment	Tier 1 – $10 copayment Tier 2 – $20 copayment Tier 3 – $35 copayment	20% coinsurance after deductible
Tier 1 – $20 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment	Tier 1 – $20 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment	20% coinsurance after deductible
Not covered Not covered	Not covered Not covered	Not covered Not covered
Not covered Not covered Not covered	Not covered Not covered Not covered	Not covered Not covered Not covered
Not covered	Not covered	Not covered

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 200 In-Network You Pay
Shots – allergy & therapeutic injections (at doctor's office, emergency room or outpatient hospital department)	10% coinsurance, no deductible	10% coinsurance after deductible
Skilled nursing facility stays (180-day per stay limit)		
Facility services	$0	$0
Professional provider services	$0	$0
Spinal manipulations and other manual medical interventions ($500 plan year limit)		
Primary care physicians	$15 copayment	$20 copayment
Specialty care providers	$25 copayment	$35 copayment
Surgery – see Hospital services		
Therapy services		
Cardiac rehabilitation therapy, chemotherapy, radiation therapy, and respiratory therapy		
• Facility services	$0	$0
• Hospital services	$0	$0
• Professional provider services	$0	$0
Occupational therapy visits, physical therapy visits, and speech therapy visits		
• Hospital services	$25 copayment	$35 copayment
• Professional provider services		
• Primary care physicians	$15 copayment	$20 copayment
• Specialty care providers	$25 copayment	$35 copayment
Wellness services		
Well child (office visits at specified intervals through age 6)		
• Primary care physicians	$15 copayment	$20 copayment
• Specialty care providers	$25 copayment	$35 copayment
• Immunizations and screening tests	10% coinsurance, no deductible	10% coinsurance, no deductible
Routine wellness – age 7 & older		
• Annual check-up visit		
• Primary care physicians	$15	$20 copayment
• Specialty care providers	$25	$35 copayment
• Immunizations, lab and x-ray services*	10% coinsurance, no deductible * Your health plan pays 90% coinsurance up to $500 per plan year for routine immunizations, lab and x-ray services	10% coinsurance, no deductible * Your health plan pays 90% coinsurance up to $500 per plan year for routine immunizations, lab and x-ray services
Preventive care	one of each per plan year	one of each per plan year
• Gynecological exam		
• Primary care physicians	$15 copayment	$20 copayment
• Specialty care providers	$25 copayment	$35 copayment
• Pap test	10% coinsurance, no deductible	10% coinsurance, no deductible
• Mammography screening – age 35 or older	10% coinsurance, no deductible	10% coinsurance, no deductible
• Prostate exam (digital rectal exam) – age 40 or older		
• Primary care physicians	$15 copayment	$20 copayment
• Specialty care providers	$25 copayment	$35 copayment
• Prostate specific antigen test – age 40 or older	10% coinsurance, no deductible	10% coinsurance, no deductible
• Colorectal cancer screenings – age 40 or older	10% coinsurance, no deductible	10% coinsurance, no deductible

Key Advantage 300 In-Network You Pay	Key Advantage 500 In-Network You Pay	High Deductible Health Plan In-Network You Pay
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$0	$0	20% coinsurance after deductible
$0	$0	20% coinsurance after deductible
$25 copayment $40 copayment	$25 copayment $40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
$0 $0 $0	$0 $0 $0	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
$40 copayment	$40 copayment	20% coinsurance after deductible
$25 copayment $40 copayment	$25 copayment $40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
$25 copayment $40 copayment 20% coinsurance, no deductible	$25 copayment $40 copayment 20% coinsurance, no deductible	$0, no deductible $0, no deductible $0, no deductible
$25 copayment $40 copayment 20% coinsurance, no deductible * Your health plan pays 80% coinsurance up to $500 per plan year for routine immunizations, lab and x-ray services	$25 copayment $40 copayment 20% coinsurance, no deductible * Your health plan pays 80% coinsurance up to $500 per plan year for routine immunizations, lab and x-ray services	$0, no deductible $0, no deductible $0, no deductible
one of each per plan year	one of each per plan year	one of each per calendar year
$25 copayment $40 copayment 20% coinsurance, no deductible 20% coinsurance, no deductible	$25 copayment $40 copayment 20% coinsurance, no deductible 20% coinsurance, no deductible	$0, no deductible $0, no deductible $0, no deductible $0, no deductible
$25 copayment $40 copayment 20% coinsurance, no deductible	$25 copayment $40 copayment 20% coinsurance, no deductible	$0, no deductible $0, no deductible $0, no deductible
20% coinsurance, no deductible	20% coinsurance, no deductible	$0, no deductible